STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, for 3 of 6 residents (Resident #22, #40, and #39) reviewed for resident rights, in that: 1. LVN A did not knock on Resident #22's door prior to entering his room. 2. CNA R stood while she fed Resident #40 at dinner time. 3. LVN A stood while she fed two unidentified residents at dinner time. 4. RN E did not knock on Resident #39's door prior to entering her room. This failure could place residents needing assistance at risk for diminished quality of life, loss of dignity and self-worth. The findings included: 1. Record review of Resident #22's face sheet, dated 5/4/23 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (hemiplegia is defined as paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness, but without complete paralysis), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and disorders of visual pathways due to vascular disorders (slow/progressive disease of narrowing/blockage of blood vessels). Record review of Resident #22's most recent quarterly MDS assessment, dated 4/19/24 revealed the resident was moderately cognitively impaired for daily decision-making skills. Observation on 4/30/24 at 3:40 p.m., during initial tour, revealed Resident #22 sitting up in bed. As Resident #22 was being interviewed by the State Surveyor, LVN A entered Resident #22's room without knocking on the door. LVN A, after realizing the State Surveyor was in the room, excused herself and left the room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/24 at 3:40 p.m., Resident #22 was asked if staff usually entered his room without knocking and Resident #22 replied, yes, they do it all the time and I hate it. During an interview on 4/30/24 at 4:05 p.m., LVN A confirmed she had not knocked on Resident #22's door before entering his room and further stated, I had been in there several times and Resident #22 was expecting me. That was my third time going in there. I do knock on the door just to let you know. 2. Record review of Resident #40's face sheet, dated 5/3/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people) Bell's Palsy (weakness in the muscles on one half of the face), protein-calorie malnutrition, dysphagia (difficulty swallowing) and cognitive communication deficit. Record review of Resident #40's most recent quarterly MDS assessment, dated 2/12/24 revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #40's comprehensive care plan, with revision date 3/5/24 revealed the resident had an ADL self-care performance deficit with interventions that included the resident required staff participation to eat. During an observation and interview on 4/30/24 at 5:18 p.m., CNA R was observed standing while feeding Resident #40. CNA R stated she was standing while feeding Resident #40 because there were no available chairs to sit on. CNA R further stated she could not leave Resident #40's side because she had already started feeding him. CNA R revealed she should not have been standing while feeding Resident #40 because she needed to be at his eye level. 3. Observation and interview on 5/1/24 at 5:02 p.m., revealed LVN A was standing while feeding two unidentified residents during dinner time. LVN A stated she could not find a chair to sit on and was supposed to be sitting down while feeding the residents for the resident's comfort. 4. Record review of Resident #39's face sheet, dated 5/3/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dysphasia (difficulty swallowing), and lack of coordination. Record review of Resident #39's most recent quarterly MDS assessment, dated 4/3/24 revealed the resident was severely cognitively impaired for daily decision-making skills. Observation on 5/3/24 at 8:48 a.m., revealed RN F, during the medication pass, entered Resident #39's room to administer medications without knocking. During an interview on 5/3/24 at 9:13 a.m., RN F stated she had announced herself to Resident #39 but realized she had not knocked on the door before entering the room. RN F stated, it's a big deal because you are going into somebody else's space and their space needs to be respected. During an interview on 5/1/24 at 5:31 p.m. the Administrator responded they shouldn't be doing that regarding staff standing while feeding the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 5:55 p.m., the DON revealed it was her expectation for staff to knock and announce themselves before entering a resident's room because you don't know what the resident is doing and that is their room. It's their right to privacy. The DON further revealed, staff should be sitting when feeding the residents because it's a dignity thing. Record review of the facility policy and procedure titled, Resident Rights, revision date 11/28/16 revealed in part, .The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States .The resident has the right to be informed of, and participate in, his or her treatment .The resident has a right to be treated with respect and dignity .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 8 residents (Resident #146) reviewed for advanced directives, in that: The facility failed to ensure Resident #146's Out-of-Hospital Do Not Resuscitate (OOH DNR) was dated and signed by a witness, 2nd physician, and or notary public which made the document invalid. This failure could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings included: Record review of Resident #146's face sheet, dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (serious condition in which your lungs cannot release enough oxygen into your blood or remove carbon dioxide effectively), acute kidney failure with tubular necrosis (a condition that causes the lack of oxygen and blood flow to the kidneys, damaging them. Tube-shaped structures in the kidneys, called tubules, filter out waste products and fluid. These structures are damaged in acute tubular necrosis), and cardiomyopathy (disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body). Further review of Resident #146's face sheet revealed the resident was identified as DNR status. Record review of Resident #146's admission MDS assessment, dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #146's comprehensive care plan, updated [DATE] revealed the resident was DNR status with interventions which included in absence of b/p, pulse, and respiration, CPR will not be initiated. Record review of Resident #146's Order Summary Report, dated [DATE] revealed the following: - DNR (Do Not Resuscitate), with order date [DATE] and no end date. Record review of Resident #146's OOH DNR, dated [DATE] revealed it was signed by the nearest living relative on [DATE] and by the physician on [DATE]. The areas for two witnesses, a notary, or 2nd physician were all blank. During an interview on [DATE] at 4:13 p.m. the DON confirmed they had deleted the DNR document from the electronic medical record so they could fix it. The DON stated they were waiting for hospice to fix the DNR. The DON stated at the facility it was still considered valid but if they called the city, they would perform CPR and that would not be honoring the resident's wishes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled DNR, undated, stated There are 2 ways we can obtain a DNR order: 1. The Out of Hospital DNR used on the Texas form. This version is universally accepted for all medical personnel in all settings 2. Physician's order for DNR. This can only be honored by your facility. I have attached the policy for DNR that covers both of these in detail. Below is a summary of requirements of a standalone physician order for DNR: (this does not apply to Out of Hospital DNR. That process remains unchanged). It can no longer just be a standalone physician order. There are certain components that must, be met. We need to have it documented in the clinical record: That the resident or resident representative is requesting the DNR. Where we contacted the physician with that request. The physician's response to the request. Use the [electronic medical record program] UDA Request for DNR in order to have all the components. This is active in [electronic medical record program] now. Scan completed Request for DNR forms into the residents document tab of PCC. The order: The DNR order takes effect at the time the order is issued. It does not need to be signed in order to be valid .This link will take you directly to the regulation. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm#166.201 I have attached the OOH DNR form and Frequently Asked Questions. These only apply to the OOH DNR .The stand alone physician order DNR should be a temporary solution for a residents wishes while the OOH DNR is obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 1 of 3 residents reviewed for PASRR (Residents #16). The facility failed to ensure Residents #16 had an accurate PASRR Level 1 Screenings indicating diagnoses of mental illness and refer the residents to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #16's face sheet, dated 5/1/24 indicated Resident #16 was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included bipolar disorder (A serious mental illness characterized by extreme mood swings) and age related cognitive decline. Record review of Resident #16's quarterly MDS assessment, dated 2/5/24, indicated Resident #16's cognition was intact for daily decision making and had a diagnosis of bipolar disorder. Record review of Resident #16's a physician's order dated 5/1/2021 indicated Resident #16 took Depakote daily for bipolar disorder. Record review of Resident #16's PASRR Level 1 Screening completed on 1/16/23 indicated in section C0100 there was no evidence of this individual having mental illness. During an interview on 5/3/24 at 1:11 p.m. the DON stated Resident #16's bipolar diagnosis was added a few days after his PASRR level 1 was completed. The DON stated they should have resubmitted a new level 1 when the diagnosis was added. The DON stated they should have done this because the resident could miss out on PASRR services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 45857 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 8 of 13 residents (Resident #14, #19, #21, #23, #31, #34, #35, and #41) reviewed for comprehensive care plans in that: The facility failed to update a plan of care to address Resident #14, #19, #21, #23, #31, #34, #35, and #41 for enhanced barrier precautions. This deficient practice could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings included: a. Record review of Resident #14's face sheet, dated 05/01/2024, revealed a [AGE] year old female with an original admitted [DATE] and a readmitted [DATE] with diagnoses including acute kidney failure (kidneys suddenly become unable to filter waste products from your blood) and neuromuscular dysfunction of bladder (problems due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination). Record review of Resident #14's most recent quarterly MDS assessment, dated 4/21/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and indicated she had an indwelling urinary catheter. Record review of Resident #14's order summary report, dated 5/01/24 revealed the following: - Ensure foley bag is in privacy bag while in bed or w/c every shift, with an order date of 1/19/24, and no end date. - Urinary Catheter 16F/10cc to gravity drainage every shift, with an order date of 2/01/24 and no end date. - provide catheter care every shift, with order date 1/19/24 and no end date. Record review of Resident #14's comprehensive care plan, with revision date 04/30/24 revealed the resident had an Indwelling Catheter: due to neuromuscular dysfunction of bladder with interventions to position catheter bag and tubing below the level of the bladder and in a privacy bag, change the catheter as ordered, and check tubing for kinks and maintain the drainage bag off the floor. The care plan did not mention the resident was on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #14 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 5/01/24 at 11:16 a.m. revealed Resident #14 was in her bedroom and the indwelling urinary catheter was draining via gravity on the left side of the bed and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. No PPE storage with gowns was noted in or around the room. b. Record review of Resident #19's face sheet, dated 4/30/24 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart disease and chronic kidney disease stage 3 (kidneys are damaged and can't filter blood the way they should) Record review of Resident #19's most recent quarterly MDS assessment, dated 2/28/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had an indwelling urinary catheter. Record review of Resident #19's order summary report, dated 4/30/24 revealed the following: - may change foley (indwelling urinary) catheter as needed for leakage sediment buildup or blockage with order date 8/12/23 and no end date. - ensure supra pubic catheter is in privacy bag while in bed or wheelchair every shift with order date 9/22/22 and no end date. - provide catheter care every shift, with order date 9/22/22 and no end date. Record review of Resident #19's comprehensive care plan, with revision date 11/30/22 revealed the resident had a supra pubic catheter related to obstructive and reflux uropathy with interventions that included to change the catheter as ordered, check tubing for kinks and maintain the drainage bag off the floor. The care plan did not mention the resident was on enhanced barrier precautions. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #19 had been identified requiring Enhanced Barrier Precautions. Observation on 4/30/24 at 11:38 a.m. revealed Resident #19 in his bedroom and the indwelling urinary catheter was draining via gravity on the left side of the bed, and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/1/24 at 9:19 a.m. revealed Resident #19 in his bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. c. Record review of Resident #21's face sheet, dated 05/01/2024, revealed a [AGE] year old female with an original admitted [DATE] and a readmitted [DATE] with diagnoses including chronic kidney disease stage 3 (kidneys are damaged and can't filter blood the way they should), dementia, and urinary tract infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's most recent quarterly MDS assessment, dated 4/19/24 revealed the resident was severely cognitively impaired for daily decision-making skills and indicated she had an indwelling urinary catheter. Record review of Resident #21's order summary report, dated 4/30/24 revealed the following: - Ensure foley bag is in privacy bag while in bed or w/c every shift, with an order date of 2/1/23, and no end date. - Urinary Catheter 16F/10ml to gravity drainage every shift for fc, with an order date of 2/1/23 and no end date. - provide catheter care every shift, with order date 2/1/23 and no end date. Record review of Resident #21's comprehensive care plan, with revision date 4/20/24 revealed the resident had an Indwelling Catheter: wound management, with interventions to position the catheter bag and tubing below the level of the bladder and in a privacy bag, change the catheter as ordered, and check tubing for kinks, and maintain the drainage bag off the floor. The care plan did not mention the resident was on enhanced barrier precautions. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #21 had been identified requiring Enhanced Barrier Precautions related to having a wound and indwelling catheter. Observation on 5/01/24 at 11:24 a.m. revealed Resident #21 was in her bedroom and the indwelling urinary catheter was draining via gravity on the right side of the bed, in a dignity bag, touching the floor, and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. No PPE storage with gowns was noted in or around the room. d. Record review of Resident #23's face sheet, dated 5/02/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving and gastrostomy status (insertion is the placement of a feeding tube through the skin and the stomach wall). Record review of Resident #23's most recent quarterly MDS assessment, dated 4/16/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had a feeding tube. Record review of Resident #23's order summary report, dated 5/2/24 revealed the following: - Enteral Feed Order every shift Cleanse g-tube site- Monitor for any signs and symptoms of infection including redness, warmth, or drainage. If noted notify MD, with an order date of 12/28/22, and no end date. Record review of Resident #23's comprehensive care plan, with revision date 4/20/24 revealed the resident required tube feeding related to swallowing problems, with interventions to provide local care to G-Tube site as ordered and monitor for signs and symptoms of infection. The care plan did not mention the resident was on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #23 had been identified requiring Enhanced Barrier Precautions related to having a feeding tube. Observation on 4/30/24 at 11:35 a.m. revealed Resident #23 was in his bedroom and a feeding tube syringe was on his bedside table. An unidentified nurse confirmed Resident #23 had a g tube. There were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions and no PPE gowns noted in the room or nearby. e. Record review of Resident #31's face sheet, dated 5/2/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included retention of urine and senile degeneration of brain. Record review of Resident #31's most recent quarterly MDS assessment, dated 4/17/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had an indwelling urinary catheter. Record review of Resident #31's order summary report, dated 5/2/24 revealed the following: - may change foley (indwelling urinary) catheter as needed for leakage sediment buildup or blockage with order date 8/12/23 and no end date. - provide catheter care every shift, with order date 6/10/22 and no end date. Record review of Resident #31's comprehensive care plan, with revision date 4/12/24 revealed the resident had bladder incontinence and had an indwelling urinary catheter with interventions that included to position the catheter bag and tubing below the level of the bladder and in a privacy bag and to provide incontinent care frequently and apply moisture barrier cream after each episode. The care plan did not mention the resident was on enhanced barrier precautions. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #31 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 11:43 a.m. revealed Resident #31 in her room with the indwelling urinary catheter on the left side of the bed draining to gravity and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/1/24 at 9:19 a.m. revealed Resident #31 in her bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. During an observation and interview on 5/2/24 at 12:54 p.m., revealed Resident #31 in the bed with the indwelling urinary catheter on the left side of the bed. CNA B was in Resident #31's room to provide catheter care but Resident #31 refused care. CNA B then stated, she would empty Resident #31's indwelling urinary catheter bag. CNA B washed her hands, put on a pair of gloves and emptied Resident #31's indwelling urinary catheter bag of urine and emptied the contents into the toilet. CNA B did not wear a gown per enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 5/2/24 at 1:09 p.m., CNA B revealed she believed enhanced barrier precautions applied to residents who received barrier cream. CNA B believed those residents identified on enhanced barrier precautions were identified on the POC (Point of Care) used by the CNA staff. CNA B stated, enhanced barrier precautions were to do with barrier cream and not anything to do with PPE (personal protective equipment). CNA B further revealed, whenever a resident had an open wound and also during wound care, then we would be wearing a gown and shield with the gloves. CNA B revealed for a resident on isolation due to an infection, there would be a yellow isolation sign on the resident's door with precautions and a cart set up with PPE on the outside of the room. f. Record review of Resident #34's face sheet, dated 4/30/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included neuromuscular dysfunction of bladder, and acute respiratory failure with hypoxia (develops when the lungs can't get enough oxygen into the blood). Record review of Resident #34's most recent quarterly MDS assessment, dated 4/20/24 revealed the resident was moderately cognitively impaired for daily decision-making skills, had an indwelling urinary catheter and had a feeding tube. Record review of Resident #34's order summary report, dated 4/30/24 revealed the following: - enteral feed order every shift check residual before medications and feedings; return contents after each check. Hold feeding if residual greater than 100 ml's, with order dated 9/8/22 and no end date. - enteral feed order every shift cleanse g-tube site and change dressing, with order date 11/24/23 and no end date. - Change foley (indwelling urinary catheter) as needed or for leakage, sediment, clogged with order date 4/30/24 and no end date. - Change foley catheter every month every night shift starting on the 10th and ending on the 10th every month for peri care with order date 3/1/23 and no end date. -Clean peg tube site with normal saline, pat dry, apply clean/dry split gauze every night shift with order date 11/24/23 and no end date. Record review of Resident #34's comprehensive care plan, with revision date 2/5/24 revealed the resident had an indwelling urinary catheter with interventions to change the catheter as ordered, check tubing for kinks and maintain the drainage bag off the floor. Further review of Resident #34's comprehensive care plan revealed the resident required enteral feedings with interventions to check for tube placement and gastric contents/residual volume per facility protocol and the comprehensive care plan did not include interventions for enhanced barrier precautions. The care plan did not mention the resident was on enhanced barrier precautions. Observation on 4/30/24 at 11:42 a.m. revealed Resident #34 in her bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #34 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 5/1/24 at 9:19 a.m. revealed Resident #34 in her bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/2/24 at 8:39 a.m., LVN C washed her hands, then took a paper towel to dry her hands, and then used the same paper towel to turn off the water faucet. LVN C then provided medications to Resident #34 via a feeding tube but did not wear a gown per enhanced barrier precautions. During an interview on 5/2/24 at 8:55 a.m., LVN C stated, she should have grabbed another paper towel to turn off the faucet because it could be considered cross contamination. LVN C further stated, whatever residue was left on my hand from drying it could be on the faucet. g. Record review of Resident #35's most recent MDS assessment, dated 4/16/24 revealed a recent admitted [DATE], diagnoses of diabetes and asthma. The MDS revealed the resident's cognition was intact and he had an indwelling catheter. Record review of Resident #35's order summary report, dated 5/2/24 revealed the following: - Urinary Catheter 20F/30cc to gravity drainage every shift for Neurogenic bladder, with an order date of 9/22/23, and no end date. - provide catheter care every shift, with order date 9/23/23 and no end date. Record review of Resident #35's comprehensive care plan, with revision date 4/20/24 revealed the resident had obstructive uropathy (excess urine accumulation in kidney(s) that causes swelling of kidneys) Catheter:20F/30cc and with interventions that included to Position catheter bag and tubing below the level of the bladder and in a privacy bag, change catheter as ordered, check tubing for kinks and maintain the drainage bag off the floor. The care plan did not mention the resident was on enhanced barrier precautions. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #35 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 11:41 a.m. revealed Resident #35 in the hallway outside of his room while Staff H cleaned his room. Resident #35 was sitting in his wheelchair and his catheter was hanging on the bottom of his chair touching the floor. The catheter bag was a solid color purple on one side and clear on the other side and urine was visible from that side. There were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. RN F and CNA G assisted resident with his catheter that was touching the floor. The staff did not have on gowns. h. Record review of Resident #41's face sheet dated 5/02/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included gastrostomy status (insertion is the placement of a feeding tube through the skin and the stomach wall). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's admission MDS assessment, dated 4/15/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had a feeding tube. Record review of Resident #41's MAR dated 5/2/24 revealed an order for enteral feed order every night shift cleanse g-tube site and was marked as completed last on 5/1/24. Record review of Resident #41's comprehensive care plan, with revision date 4/30/24 revealed the resident required tube feeding related to swallowing problems, with interventions clean insertion site daily as ordered, monitoring for s/s infection or breakdown. The care plan did not mention the resident was on enhanced barrier precautions. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #41 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 10:37 a.m. revealed Resident #41 was in his bedroom and a feeding tube syringe was on his bedside table. There were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions and no PPE gowns noted in the room or nearby. During an interview on 5/2/24 at 1:43 p.m., the DON revealed the facility had received a provider letter from corporate on enhanced barrier precautions, recently. The DON stated the nurse managers were responsible for updating the care plans and the DON was responsible for checking they were added to the care plans. The DON stated she thought she checked the care plans to see if enhanced barrier precautions were added to the residents' plan of care. The DON further revealed, residents were at risk for infection if staff were not following the enhanced barrier precautions. During an interview on 5/2/24 at 2:17 p.m., the ADON revealed residents on enhanced barrier precautions should have it care planned because it was part of their plan of care. The ADON stated she was a nurse manager but was not tasked with adding the enhanced barrier precautions to the care plans. Record review of the facility training document titled Enhanced Barrier Precaution, dated 3/27/24 revealed in part, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities . The facility will utilize postings outside the room and [electronic medical record program] to communicate to staff if a resident requires EBP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 residents (Resident #21 and Resident #35) reviewed for indwelling urinary catheter care, in that: 1. The facility failed to ensure Resident #21's and Resident #35's indwelling urinary catheter drainage bags were not touching the floor and were in a dignity bag. This failure could place residents with indwelling urinary catheter devices at risk for the development of new or worsening urinary tract infections. The findings included: Record review of Resident #21's face sheet, dated 05/01/2024, revealed a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE] with diagnoses including chronic kidney disease stage 3 (kidneys are damaged and can't filter blood the way they should), dementia, and urinary tract infection. Record review of Resident #21's most recent quarterly MDS assessment, dated 4/19/24 revealed the resident was severely cognitively impaired for daily decision-making skills and indicated she had an indwelling urinary catheter. Record review of Resident #21's comprehensive care plan, with revision date 4/20/24 revealed the resident had Indwelling Catheter: wound management, with interventions to position the catheter bag and tubing below the level of the bladder and in a privacy bag, change the catheter as ordered, and check tubing for kinks and maintain the drainage bag off the floor. Record review of Resident #21's order summary report, dated 4/30/24 revealed the following: - Ensure foley bag was in privacy bag while in bed or w/c every shift, with an order date of 2/1/23, and no end date. - Urinary Catheter 16F/10ml to gravity drainage every shift for fc, with an order date of 2/1/23 and no end date. - provide catheter care every shift, with order date 2/1/23 and no end date. Observation on 5/01/24 at 11:24 a.m. revealed Resident #21 was in her bedroom and the indwelling urinary catheter was draining via gravity on the right side of the bed, in a dignity bag, touching the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #35's most recent MDS assessment, dated 4/16/24 revealed a recent admitted [DATE], diagnoses of diabetes and asthma. The MDS revealed the resident's cognition was intact and he had an indwelling catheter. Record review of Resident #35's comprehensive care plan, with revision date 4/20/24 revealed the resident had obstructive uropathy (excess urine accumulation in kidney(s) that causes swelling of kidneys) Catheter:20F/30cc and with interventions that included position catheter bag and tubing below the level of the bladder and in a privacy bag, change catheter as ordered, check tubing for kinks and maintain the drainage bag off the floor. Record review of Resident #35's order summary report, dated 5/2/24 revealed the following: - Urinary Catheter 20F/30cc to gravity drainage every shift for Neurogenic bladder, with an order date of 9/22/23, and no end date. - provide catheter care every shift, with order date 9/23/23 and no end date. - Ensure foley bag is in privacy bag while in bed or w/c every shift, with a start date of 9/22/23 and no end date. Observation on 4/30/24 at 11:41 a.m. revealed Resident #35 in the hallway outside his room while staff H cleaned his room. Resident #35 was sitting in his wheelchair and his catheter was hanging on the bottom of his chair touching the floor. The catheter bag was a solid color purple on one side and clear on the other side and urine was visible from the clear side. During an interview on 4/30/24 at 11:47 a.m. RN F stated CNA G transferred Resident #35 to his wheelchair that day and hung his catheter on his wheelchair. RN F stated the catheter bag should not be touching the floor because it could become contaminated. RN F then called CNA G into the room to help her adjust the catheter so it would not touch the floor. During an interview on 5/1/24 at 11:26 a.m. CNA G stated Resident #21's catheter bag was touching the floor. CNA G stated he had a basin to use to keep the catheter and dignity bag from touching the floor, but he did not use it. CNA G stated resident's catheters should not be touching the floor because they could get damaged. During an interview on 5/2/23 at 6:13 p.m. the DON stated the catheter bags they have were covered on one side. The DON stated it provided privacy while the resident was in bed but not full privacy when the resident was out of bed. The DON stated the catheters should still be placed in a dignity bag for privacy and the catheters should not be touching the floor because it could tear or rip open. The DON stated they had basins they could use to put under the catheters to keep them from touching the floor. Record review of the facility's policy titled Catheter Care, dated 2/13/07, stated General Guide lines .keep tubing off floor .10. Be sure the catheter tubing and drainage bag are kept off the floor .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #39) reviewed for enteral feeding tubes in that: 1. RN F did not ensure Resident #39's head of bed was elevated to at least 30 degrees. These failures could place residents at risk for complications of enteral feeding. The findings included: Record review of Resident #39's face sheet, dated 5/3/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing) following cerebrovascular disease (disorders in which an area of the brain is affected by bleeding of the brain), gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach) and protein-calorie malnutrition. Record review of Resident #39's most recent quarterly MDS assessment, dated 4/3/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had a feeding tube. Record review of Resident #39's comprehensive care plan, with revision date 12/22/23 revealed the resident had gastroesophageal reflux with interventions that included to avoid lying down for at least 1 hour after eating, and to keep the head of bed elevated and give medications as ordered. Record review of Resident #39's order summary report, dated 5/3/24 revealed the following: - enteral feed order, every night shift change syringe every 24 hours with order date 11/27/23 and no end date - enteral feed order, every shift, flush tube with 30 ml water before and after medication and feedings, with order date 11/27/23 and no end date - enteral feed order, every shift head of bed up at least 30 degrees during administration of enter formula or water, with order date 11/27/23 and no end date - Carvedilol 25 mg, give 1 tablet via g-tube (feeding tube) two times a day related to hypertension, with order date 12/13/23 and no end date -Isosource 1.5, 250 ml via g-tube five times per day per family request, with order date 1/22/24 and no end date - Aspirin 81 mg, give 1 tablet via g-tube every day shift related to hypertension, with order date 11/27/23 and no end date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Atorvastatin Calcium tablet 40 mg, give 1 tablet every day shift via g-tube related to cerebral infarction, with order date 11/27/23 and no end date - Glipizide 5 mg tablet via g-tube every day shift related to type 1 diabetes, with order date 11/27/23 and no end date - Lisinopril 20 mg, give 1 tablet via g-tube two times a day, with order date 1/4/24 and no end date - Lactulose 10 mg/15 ml, give 30 milliliters by mouth one time a day for constipation, with order date 1/15/24 and no end date Observation on 5/3/24 at 9:01 a.m. revealed RN F administered medications to Resident #39 via the feeding tube but did not elevate the resident's head of the bed to 30 degrees. Resident #39 was observed laying flat on the bed and two pillows were observed on either side of the resident's head. During an interview on 5/3/24 at 9:13 a.m., RN F revealed Resident #39's head of the bed might not have been elevated to 30 degrees and if not, the resident could regurgitate. During a follow up interview on 5/3/24 at 12:34 p.m., the DON revealed it was her expectation for the nursing staff to ensure the head of the bed was elevated when providing feedings or medications to a resident who had a feeding tube to prevent aspiration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals, and preferences for 1 of 2 residents (Resident #15) reviewed for oxygen therapy in that: Resident #15's oxygen concentrator filter was covered in a thick white substance and the oxygen setting was lower than the physician's orders. This failure could affect residents who received respiratory therapy and put them at risk for inadequate or inappropriate amounts of oxygen delivery. The findings included: Record review of Resident #15's face sheet, dated 5/1/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (diseases that cause airflow blockage and breathing-related problems), heart disease, and age-related cognitive decline. Record review of Resident #15's most recent quarterly MDS assessment, dated 4/19/24 revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #15's order summary report, dated 5/1/24 revealed the following: - change or clean the filter of the nebulizer machine every night shift every Sunday, with order date 6/8/23 and no end date - may use oxygen at 4 liters per minute via nasal canula every shift for shortness of breath, with order date 2/27/24 and no end date - per hospice MD, keep patient O2 saturation at 88%-92% every shift, with order date 4/10/24 and no end date Record review of Resident #15's comprehensive care plan, with revision date 4/12/24 revealed the resident received oxygen therapy per hospice services and interventions to include oxygen at 4 liters per minute via nasal canula. Observation on 4/30/24 at 9:42 a.m. revealed Resident #15 and the oxygen concentrator operating via nasal canula at 3 liters per minute. Resident #15's oxygen concentrator had two filters and the filter on the right of the concentrator was covered in a white substance. Observation on 5/1/24 at 8:43 a.m. revealed Resident #15 and the oxygen concentrator operating via nasal canula at 3 liters per minute. Resident #15's oxygen concentrator had two filters and the filter on the right of the concentrator was covered in a white substance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/1/24 at 3:40 p.m., revealed Resident #15 and the oxygen concentrator operating via nasal canula at 3 liters per minute. Resident #15's oxygen concentrator had two filters and the filter on the right of the concentrator was covered in a white substance. LVN A observed Resident #15 and revealed the resident was receiving hospice services and the oxygen concentrator would be operating at 3 liters to 4 liters depending on the resident's oxygen saturation. LVN A stated she had never checked the oxygen concentrator filters and stated, my main job is to make sure the concentrator is working. LVN A further stated she didn't even know where the filters were located on the oxygen concentrators. LVN A, after observing the oxygen filters stated, the oxygen filter on the right of the concentrator needs to be cleaned, it looks like dust. LVN A further stated, since Resident #15 was receiving hospice services, and the oxygen concentrator was provided by hospice, it's hospice equipment and they should be checking and changing the oxygen filter. During an observation and interview on 5/1/24 at 3:54 p.m., the DON confirmed Resident #15 was receiving hospice services and was receiving continuous oxygen. The DON stated the facility nursing staff were responsible for ensuring the oxygen filters on the concentrators were kept clean and believed it was even included in the physician's orders. The DON stated, she could not tell what the gray stuff on the oxygen filters were and confirmed the oxygen concentrator was set at 3 liters and should have been set at 4 liters per the physician's orders. The DON stated, though the oxygen concentrator was set at different liters, if the resident were not getting enough oxygenation, the resident could have labored breathing and confusion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 1 resident (Resident #16) reviewed for dialysis: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #16. This deficient practice could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: Record review of Resident #16's face sheet, dated 5/1/24 indicated Resident #16 was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included acute kidney failure, hyperlipidemia (elevated cholesterol), glaucoma (increased pressure within the eyeball causing gradual loss of sight), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis), and dependence on renal dialysis. Record review of Resident #16's quarterly MDS assessment, dated 2/5/24, indicated Resident #17 cognition was intact for daily decision making and received dialysis. Record review of Resident #16's comprehensive care plan, with revision date 4/20/24 revealed: -the resident received hemodialysis related to renal failure with interventions to monitor/document/report to MD PRN any s/sx of infection to access site: redness, swelling, warmth or drainage, monitor/document/report to MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds, Monitor/document/report to MD PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock, Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations, and BP immediately. -Resident #16 is resistive to care, refuses dialysis, vitals .with intervention to allow the resident to make decisions about treatment regime, to provide sense of control. Record review of Resident #16's a physician's order dated 5/1/2021 indicated to assess dialysis device to his right chest with a start date of 1/27/23 and no end date, and an order for dialysis every Tuesday, Thursday, and Saturday. During an interview on 4/30/24 at 10:49 a.m. Resident #16 stated he started going to dialysis in November. Resident #16 stated staff used to take his blood pressure before dialysis, at dialysis, and upon return from dialysis. Resident #16 stated they had stopped taking his vitals before he went to dialysis. Record review of Resident #16's Dialysis Communications Record revealed dates 3/5/24 through 4/27/24 contained no pre assessment vitals done by the nursing facility nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/3/24 at 4:25 p.m. the DON stated Resident #16 refused his vitals before dialysis. The DON stated staff should document he refused his vitals. The DON stated if staff did not obtain the residents vitals prior to dialysis they would not notice a change from the time he left the facility to the time they were taken at the dialysis center. A dialysis policy was requested and not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents for 1 of 5 residents (Resident #11) reviewed for medication administration, in that: The facility failed to ensure Resident #11 was administered Methadone (an opioid prescribed for pain) as ordered by the physician. This deficient practice could place residents at risk of not receiving the intended therapeutic effect of medications and could result in diminished health and well-being. The findings included: Record review of Resident #11's face sheet, dated 5/3/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people), blindness in one eye and anxiety disorder (a normal reaction to stress in an intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #11's most recent quarterly MDS assessment, dated 2/16/24 revealed the resident was cognitively intact for daily decision-making skills, was treated with opioids and required medication for pain management. Record review of Resident #11's comprehensive care plan, revision date 5/1/24 revealed the resident had a potential for uncontrolled pain with interventions that included to anticipate the resident's need for pain relief and respond immediately to any complaint of pain and to monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Further review of comprehensive care plan revealed Resident #11 was on pain medication therapy with intervention to administer medications as ordered. Record review of Resident #11's Order Summary Report, dated 5/3/24 revealed the following: - when alert, monitor for pain every shift using a scale of 0-10, if anything greater than 0 is noted, indicate in the space provided, provide relief and document in progress notes every shift, with order date 4/3/23 and no end date - Methadone 10 mg oral tablet, give 1 tablet by mouth two times a day for pain, with order date 4/3/23 and no end date Record review of Resident #11's Methadone narcotic log for April 2024 revealed the resident had a 60-day supply of Methadone, beginning 4/1/24, to be administered twice a day. Further review of Resident #11's Methadone narcotic log revealed the resident received the last dose of Methadone on 4/30/24 at 7:00 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's Medication Administration Record (MAR) for April 2024 revealed Med Aide Q documented the code 9 on the Methadone scheduled evening dose for 4/30/24 which indicated Other/See Nurse Notes. Record review of the nursing progress note, dated 4/30/24 and authored by Med Aide Q revealed, in response to the MAR code 9 revealed the following: Administered, Med Aide Q Record review of Resident #11's MAR for May 2024 revealed the morning dose for Methadone scheduled on 5/1/24 was blank. Record review of Resident #11's MAR for May 2024 revealed Med Aide Q documented the code 9 on the Methadone scheduled evening dose for 5/1/24 which indicated Other/See Nurse Notes. Record review of the nurse's progress note dated 5/1/24 at 2:57 p.m. and authored by Med Aide Q revealed the following: Methadone HCl Oral Tablet 10 MG, Give 1 tablet by mouth two times a day for Pain. See Nurse's Notes Med Aide Q During an interview on 4/30/24 at 10:48 a.m., Resident #11 revealed he was having issues with the facility obtaining Methadone prescribed for pain and was told the facility ran out of the medication on the morning of 4/30/24. Resident #11 stated an unidentified nurse had been telling me for 3 days that it (Methadone) needed to be filled. During a follow-up interview on 5/1/24 at 3:14 p.m., Resident #11 stated he did not receive the scheduled morning dose of Methadone. During an interview on 5/1/24 at 3:31 p.m., Med Aide Q revealed she had administered Resident #11 an evening dose of Methadone on 4/30/24 and an evening dose of Methadone on 5/1/24. Med Aide Q stated, the nursing progress notes she had written indicated she gave Resident #11 his scheduled Methadone. Med Aide Q revealed the last dose of Methadone received by Resident #11 was the evening dose scheduled on 5/1/24. Med Aide Q further revealed Resident #11's Methadone was out and should be coming in tonight. Med Aide Q revealed the DON and the ADON had been notified Resident #11's Methadone medication had run out. Med Aide Q stated, not sure what would happen to Resident #11 if he were not taking it (Methadone), I know it's only scheduled one time daily with me, don't know what it's for. During an interview on 5/1/24 at 4:02 p.m., the DON revealed the NP had been notified about Resident #11 running out of Methadone and was waiting for the MD to sign for the prescription. The DON stated she had talked to the NP and had been told the prescription would be signed by the MD and the Methadone should arrive later in the day. The DON stated if the Resident #11 did not receive the Methadone as scheduled, the resident could suffer withdrawals. During a follow-up interview on 5/2/24 at 6:00 p.m., the DON stated the documentation on the narcotic log should match the documentation on the nursing progress notes. The DON revealed she needed to look more into the situation to determine any discrepancy and only stated, the narcotic log should match the MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure titled, Medication Administration Procedures, dated 2003 revealed in part, .All medications are administered by licensed medical or nursing personnel .If a dose of regularly scheduled medication is withheld .the nurse is to initial and circle the front of the medication administration record in the space provided for that dosage administration and an explanatory note is to be entered in the nursing notes .Defining the schedules for administering medications to .Maximize the effectiveness (optimal therapeutic effect) of the medication .The 10 rights of medication should always be adhered to .Right documentation .Any deviation from specified and recommended procedures in dispensing or administering medications to the resident requires documented approval .and shall be in concurrence with current statutes and regulations .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 7.14% based on 2 out of 28 opportunities, which involved 2 of 5 Residents (Resident #18 and #28) reviewed for medication administration, in that: Med Aide D failed to ensure Resident #18, and Resident #28 received the correct dosage of Vitamin D. These failures could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: a. Record review of Resident #18's face sheet, dated 5/3/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), personal history of infectious and parasitic diseases and morbid obesity. Record review of Resident #18 s order summary report, dated 5/2/24 revealed the following: - Vitamin D (Cholecalciferol) oral tablet 50 mcg (2000 Unit) give 1 tablet by mouth one time a day for supplement, with order date 8/22/23 and no end date b. Record review of Resident #28's face sheet, dated 5/3/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included protein-calorie malnutrition, type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and dementia. Record review of Resident #28's order summary report, dated 5/2/24 revealed the following: - Cholecalciferol (Vitamin D) 1000 Unit, give 1 tablet by mouth one time a day for supplement, with order date 8/7/22 and no end date. Observation on 5/2/24 at 7:23 a.m., revealed Med Aide D obtained the Vitamin D bottle labeled 10 mcg (400 Unit) and administered 2 tablets to Resident #18 which equaled to 20 mcg (800 Unit), instead of the scheduled 50 mcg (2000 Unit). Observation on 5/2/24 at 7:36 a.m., revealed Med Aide D obtained the Vitamin D bottle labeled 10 mcg (400 Unit) and administered 1 tablet to Resident #28 instead of the scheduled 1000 Unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 10:29 a.m., Med Aide D revealed she had used the same bottle of Vitamin D for Resident #18 and Resident #28 and realized she had underdosed both residents. Med Aide D revealed the cap on the top of the bottle had 1000 Units written on the top and followed what was written on the cap and not what was noted on the label. Med Aide D revealed Resident #18 and Resident #28 did not receive the intended dose and could result in a Vitamin D deficiency. During an interview on 5/2/24 at 5:42 p.m., the DON revealed it was her expectation for staff, when administering medications, they should be checking the order and the label on the medication for accuracy. The DON further revealed, under dosing Vitamin D could result in the resident not receiving the therapeutic dose as prescribed. Record review of the facility policy and procedure titled Medication Administration Procedures, dated 2003 revealed in part, .The 10 rights of medication should always be adhered to .Right dose .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 4 medication carts (West Wing medication cart) and 1 of 21 resident rooms (Resident #11) reviewed for storage of drugs. 1. The [NAME] Wing medication cart was left unlocked and unattended. 2. The facility failed to ensure medications were not left at the bedside for Resident #11. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings included: 1. Observation on 5/2/24 at 11:18 a.m., during the medication pass, revealed LVN A opened the [NAME] Wing medication cart to administer medications to a resident on the [NAME] Wing. LVN A then walked across the hall to the resident's room to administer medications. LVN A left the [NAME] Wing medication cart unlocked and unattended in the main hall between the units and the dining room area. During an interview on 5/2/24 at 11:29 a.m., LVN A revealed she had left the [NAME] Wing medication cart unlocked and unattended because she was nervous. LVN A revealed the [NAME] Wing medication cart should never be left unlocked and unattended because residents were known to wander the unit and I could be robbed; people could take stuff and overdose. LVN A further stated, we have true addicts here in the facility. 2. Record review of Resident #11's face sheet, dated 5/3/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people), blindness in one eye and anxiety disorder (a normal reaction to stress in an intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #11's most recent quarterly MDS assessment, dated 2/16/24 revealed the resident was cognitively intact for daily decision-making skills. Record review of Resident #11's Order Summary Report, dated 5/3/24 revealed the following: - Benadryl allergy oral tablet 25 mg, give 1 tablet by mouth every 6 hours as needed for itching, with order date 4/3/23 and no end date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/1/24 at 3:14 p.m., revealed Resident #11 sitting up in bed and a medication cup observed on the bedside table with two pink oval tablets at the foot of the bed. Resident #11 stated, he had been given the pills by Med Aide D earlier that morning but had forgotten to take them because he fell asleep. Resident #11 identified the two pink oval tablets as Benadryl. Resident #11 further stated, Med Aide D gave him a bunch of other medications but had not taken those either. Resident #11 stated, with me they leave medications. During an observation and interview on 5/1/24 at 3:31 p.m., Med Aide Q revealed Resident #11 usually went to the medication cart and received his medications from her. Med Aide Q stated, Resident #11 could not self-medicate because all the resident's medications were kept in the medication cart. Med Aide Q revealed she had given Resident #11 medications that morning but I never leave anything (medications) in the room with him, we can't do that, I was taught not to leave medications in the room, you have to watch them take it. Med Aide Q revealed, another resident could take the Benadryl pills and have an allergic reaction or Resident #11 could forget to take them. During an interview on 5/2/24 at 6:00 p.m., the DON revealed there were no residents in the facility who were able to self-medicate. The DON stated, medications cannot be left at the bedside, it shouldn't happen, and anybody could take them and have an adverse reaction or overdose. Record review of the facility policy and procedure, titled Medication Administration Procedures, 2003 revealed in part, .All medications are administered by licensed medical or nursing personnel .During the medication administration process, the unlocked side of the cart must always be in full view of the nurse . After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 45857 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to ensure food was properly labeled. 2. The facility failed to ensure expired food products were discarded. 3. The facility failed to ensure food with freezer burn was discarded. 4. The facility failed to ensure a bag of spaghetti was not spilled on the shelf and a container of sugar was closed. 5. The facility failed to ensure staff did not keep personal drinks on the food prep tables. 6. The facility failed to ensure staff did not lick their fingers while placing dietary cards on resident food trays. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: During an observation on [DATE] at 9:01 a.m. in the walk in fridge/freezer a pound of strawberries were observed with no date, one bag of leafy greens contained no date or label, a plastic bag of mixed frozen vegetables had ice buildup on it, was open and were not able to read an expiration date, and a bag of croissant dough had no date on it and had ice buildup on it. An open box with a date of [DATE] contained 1 container of hummus with expiration date of [DATE]. In the dry food storage, a bag of spaghetti was open and spilled onto the shelf and an open bag of sugar was seen on the shelf. During an observation and interview on [DATE] at 9:01 a.m. the DM stated the strawberries belonged to a staff member, they were not supposed to be in there, and he would throw them out. The DM stated the bag of leafy greens belonged to the activities director and it should have been sealed in a bag, dated, and he would throw it out. The DM stated the bag of mixed vegetables had ice on it and he could not identify a date. The DM stated if they could not see a date then it had to be thrown out. The DM stated opened items were kept for 6 days and then discarded. The DM stated the bag of croissant dough did not have a date that could be read, had ice on it, and should be thrown out. The DM stated the box of hummus was placed in the fridge by the activities director and they should not keep expired items. The DM stated spaghetti was the alternative meal for the day and picked up the open package of spaghetti and threw it out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on [DATE] at 9:58 a.m. a container of sugar was open. During an interview on [DATE] at 9:58 a.m. Dietary Aide N stated the sugar container should be covered and then covered the sugar container. During an observation on [DATE] at 10:39 a.m. a cart in the kitchen next to the food prep table had a green metal cup with a straw. There was a green sanitizer bucket next to the cup and two oven mitts on top of the cart. During an observation on [DATE] at 10:58 a.m. Dietary Aide L placed dietary preference sheets on the resident food tray. Dietary Aide L licked her finger then grabbed a sheet and placed it on the tray. This surveyor asked Dietary Aide L if she was licking her fingers. Dietary L stated she was and continued to place the papers on the tray. Temporary Dietary Manager O asked Dietary Aide L to go wash her hands. During an interview on [DATE] at 10:58 a.m. Dietary Aide L stated she should not have licked her fingers when she placed the dietary preference sheets on the resident food trays because it was not sanitary, and residents could get sick. During an interview on [DATE] at 11:38 a.m. Cook K stated the green cup was hers and she removed it from the kitchen because it was not supposed to be in the kitchen. During an interview on [DATE] at 12:25 p.m. the Activity Director stated she had a current food handlers' certificate. The Activity Director stated the DM instructed her to place any of the food items she used for residents together in a bag and put a date on it. The Activity Director stated the leafy greens and hummus were not items she had used for residents. The Activity Director stated dietary staff were responsible for the kitchen. Record review of the facility's policy, titled Dietary Food Service Personnel Policy and Procedures, dated 2012, stated The next pages of information are designed for dietary employees to acquaint you with the rules and personnel procedures of this department. It is important that these be followed at all times in order to . maintain the efficiency of the department and make this a pleasant place for you and others to work. The resident is the reason that we are here and our job in the residents' care plan is to serve attractive, appetizing, nourishing, and high-quality food to help keep them healthy .Sanitation and Food Handling .3. Wash your hands (with soap and hot water) before starting work, after coughing, or sneezing .touching something that is not clean and then handling food can cause food poisoning .8. Work surfaces must be kept as neat and clean as possible during preparation and service .11. All unused food must be securely covered. All items are to be dated and labeled as to their content. Store items in their original container unless instructed to do otherwise .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 6 residents (Resident #11) reviewed for accuracy of medical records in that: Med Aide Q documented she gave Resident #11's afternoon dose of Methadone (prescribed for pain) on 4/30/24 and 5/1/24 after Resident #11 received his last dose of Methadone on 4/30/24 during the scheduled morning dose. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Record review of Resident #11's face sheet, dated 5/3/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people), blindness in one eye and anxiety disorder (a normal reaction to stress in an intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #11's most recent quarterly MDS assessment, dated 2/16/24 revealed the resident was cognitively intact for daily decision-making skills, was treated with opioids and required medication for pain management. Record review of Resident #11's comprehensive care plan, revision date 5/1/24 revealed the resident had a potential for uncontrolled pain with interventions that included to anticipate the resident's need for pain relief and respond immediately to any complaint of pain and to monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Further review of comprehensive care plan revealed Resident #11 was on pain medication therapy with intervention to administer medications as ordered. Record review of Resident #11's Order Summary Report, dated 5/3/24 revealed the following: - Methadone 10 mg oral tablet, give 1 tablet by mouth two times a day for pain, with order date 4/3/23 and no end date Record review of Resident #11's Methadone narcotic log for April 2024 revealed the resident had a 60-day supply of Methadone, beginning 4/1/24, to be administered twice a day. Further review of Resident #11's Methadone narcotic log revealed the resident received the last dose of Methadone on 4/30/24 at 7:00 a.m. Record review of Resident #11's Medication Administration Record (MAR) for April 2024 revealed Med Aide Q documented the code 9 on the Methadone scheduled evening dose for 4/30/24 which indicated Other/See Nurse Notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the nursing progress note, dated 4/30/24 and authored by Med Aide Q revealed, in response to the MAR code 9 revealed the following: Administered, Med Aide Q Record review of Resident #11's MAR for May 2024 revealed the morning dose for Methadone scheduled on 5/1/24 was blank. Record review of Resident #11's MAR for May 2024 revealed Med Aide Q documented the code 9 on the Methadone scheduled evening dose for 5/1/24 which indicated Other/See Nurse Notes. Record review of the nurse's progress note dated 5/1/24 at 2:57 p.m. and authored by Med Aide Q revealed the following: Methadone HCl Oral Tablet 10 MG, Give 1 tablet by mouth two times a day for Pain. See Nurse's Notes Med Aide Q During an interview on 4/30/24 at 10:48 a.m., Resident #11 revealed he was having issues with the facility obtaining Methadone prescribed for pain and was told the facility ran out of the medication on the morning of 4/30/24. Resident #11 stated an unidentified nurse had been telling me for 3 days that it (Methadone) needed to be filled. During a follow-up interview on 5/1/24 at 3:14 p.m., Resident #11 stated he did not receive the scheduled morning dose of Methadone for 5/1/24. During an interview on 5/1/24 at 3:31 p.m., Med Aide Q revealed she had administered Resident #11 an evening dose of Methadone on 4/30/24 and an evening dose of Methadone on 5/1/24. Med Aide Q stated, the nursing progress notes she had written indicated she gave Resident #11 his scheduled Methadone. Med Aide Q revealed the last dose of Methadone received by Resident #11 was the evening dose scheduled on 5/1/24. Med Aide Q revealed, at the time of the interview, Resident #11 was out of Methadone medication. Med Aide Q stated, not sure what would happen to Resident #11 if he were not taking it (Methadone), I know it's only scheduled two times daily with me, don't know what it's for. During a follow-up interview on 5/2/24 at 6:00 p.m., the DON stated the documentation on the narcotic log should match the documentation on the nursing progress notes. The DON revealed she needed to look more into the situation to determine any discrepancy and only stated, the narcotic log should match the MAR. Record review of the facility policy and procedure titled Medication Administration Procedures, dated 2003 revealed in part, .If a dose of regularly scheduled medication is withheld .the nurse is to initial and circle the front of the medication administration record in the space provided for that dosage administration and an explanatory note is to be entered in the nursing notes .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 10 of 13 residents (Resident #14, #19, #18, #21, #22, #23, #31, #34, #35, and #41) reviewed for infection control, in that: 1. The facility failed to utilize enhanced barrier precautions for Resident #14, #19, #21, #23, #31, #34, #35, and #41. 2. LVN A failed to utilize appropriate hand hygiene and infection control principles. LVN A did not perform hand hygiene between glove changes and obtained an accu check (a test used to obtain a rapid assessment of blood glucose concentration results; finger stick blood sampling) on Resident #22 without properly sanitizing the site. 3. LVN C failed to utilize appropriate hand hygiene and infection control principles. LVN C washed her hands and used the same paper towel to dry her hands and to turn off the water faucet. 4. Med Aide D failed to utilize appropriate hand hygiene and infection control principles. Med Aide D washed her hands and used the same paper towel to dry her hands and to turn off the water faucet. These deficient practices could place residents at risk of infection for transmission of communicable diseases and a decline in health. The findings included: 1. a. Record review of Resident #14's face sheet, dated 05/01/2024, revealed a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE] with diagnosis including acute kidney failure (kidneys suddenly become unable to filter waste products from your blood) and neuromuscular dysfunction of bladder (problems due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination). Record review of Resident #14's most recent quarterly MDS assessment, dated 4/21/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and indicated she had an indwelling urinary catheter. Record review of Resident #14's order summary report, dated 5/01/24 revealed the following: - Ensure foley bag is in privacy bag while in bed or w/c every shift, with an order date of 1/19/24, and no end date. - Urinary Catheter 16F/10cc to gravity drainage every shift, with an order date of 2/01/24 and no end date. - provide catheter care every shift, with order date 1/19/24 and no end date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #14's comprehensive care plan, with revision date 04/30/24 revealed the resident had Indwelling Catheter: due to neuromuscular dysfunction of bladder with interventions to position catheter bag and tubing below the level of the bladder and in a privacy bag, change the catheter as ordered, and check tubing for kinks and maintain the drainage bag off the floor. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #14 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 5/01/24 at 11:16 a.m. revealed Resident #14 was in her bedroom and the indwelling urinary catheter was draining via gravity on the left side of the bed and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. No PPE storage with gowns was noted in or around the room. b. Record review of Resident #19's face sheet, dated 4/30/24 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart disease and chronic kidney disease stage 3 (kidneys are damaged and can't filter blood the way they should) Record review of Resident #19's most recent quarterly MDS assessment, dated 2/28/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had an indwelling urinary catheter. Record review of Resident #19's order summary report, dated 4/30/24 revealed the following: - may change foley (indwelling urinary) catheter as needed for leakage sediment buildup or blockage with order date 8/12/23 and no end date. - ensure supra pubic catheter is in privacy bag while in bed or wheelchair every shift with order date 9/22/22 and no end date. - provide catheter care every shift, with order date 9/22/22 and no end date. Record review of Resident #19's comprehensive care plan, with revision date 11/30/22 revealed the resident had a supra pubic catheter related to obstructive and reflux uropathy with interventions that included to change the catheter as ordered, check tubing for [NAME] and maintain the drainage bag off the floor. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #19 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 11:38 a.m. revealed Resident #19 in his bedroom and the indwelling urinary catheter was draining via gravity on the left side of the bed and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/1/24 at 9:19 a.m. revealed Resident #19 in his bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Record review of Resident #21's face sheet, dated 05/01/2024, revealed an [AGE] year old female with an original admitted [DATE] and a readmitted [DATE] with diagnosis including chronic kidney disease stage 3 (kidneys are damaged and can't filter blood the way they should), dementia, and urinary tract infection. Record review of Resident #21's most recent quarterly MDS assessment, dated 4/19/24 revealed the resident was severely cognitively impaired for daily decision-making skills and indicated she had an indwelling urinary catheter. Record review of Resident #21's order summary report, dated 4/30/24 revealed the following: - Ensure foley bag is in privacy bag while in bed or w/c every shift, with an order date of 2/1/23, and no end date. - Urinary Catheter 16F/10ml to gravity drainage every shift for fc, with an order date of 2/1/23 and no end date. - provide catheter care every shift, with order date 2/1/23 and no end date. Record review of Resident #21's comprehensive care plan, with revision date 4/20/24 revealed the resident had Indwelling Catheter: wound management, with interventions to position catheter bag and tubing below the level of the bladder and in a privacy bag, change the catheter as ordered, and check tubing for kinks and maintain the drainage bag off the floor. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #21 had been identified requiring Enhanced Barrier Precautions related to having wounds and an indwelling catheter. Observation on 5/01/24 at 11:24 a.m. revealed Resident #21 was in her bedroom and the indwelling urinary catheter was draining via gravity on the right side of the bed, in a dignity bag, touching the floor, and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. No PPE storage with gowns was noted in or around the room. d. Record review of Resident #23's face sheet, dated 5/02/24 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving and gastrostomy status (insertion is the placement of a feeding tube through the skin and the stomach wall). Record review of Resident #23's most recent quarterly MDS assessment, dated 4/16/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had a feeding tube. Record review of Resident #23's order summary report, dated 5/2/24 revealed the following: - Enteral Feed Order every shift Cleanse g-tube site- Monitor for any s/s of infection including redness, warmth, or drainage. If noted notify MD, with an order date of 12/28/22, and no end date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #23's comprehensive care plan, with revision date 4/20/24 revealed the resident required tube feeding related to swallowing problems, with interventions Provide local care to G-Tube site as ordered and monitor for s/sx of infection. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #23 had been identified requiring Enhanced Barrier Precautions related to having a feeding tube. Observation on 4/30/24 at 11:35 a.m. revealed Resident #23 was in his bedroom and a feeding tube syringe was on his bedside table. An unidentified nurse confirmed Resident #23 had a g tube. There were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions and no PPE gowns noted in the room or nearby. e. Record review of Resident #31's face sheet, dated 5/2/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included retention of urine and senile degeneration of brain. Record review of Resident #31's most recent quarterly MDS assessment, dated 4/17/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had an indwelling urinary catheter. Record review of Resident #31's order summary report, dated 5/2/24 revealed the following: - may change foley (indwelling urinary) catheter as needed for leakage sediment buildup or blockage with order date 8/12/23 and no end date. - provide catheter care every shift, with order date 6/10/22 and no end date. Record review of Resident #31's comprehensive care plan, with revision date 4/12/24 revealed the resident had bladder incontinence and had an indwelling urinary catheter with interventions that included to position catheter bag and tubing below the level of the bladder and in a privacy bag and to provide incontinent care frequently and apply moisture barrier cram after each episode. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #31 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 11:43 a.m. revealed Resident #31 in her room with the indwelling urinary catheter on the left side of the bed draining to gravity and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/1/24 at 9:19 a.m. revealed Resident #31 in her bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/2/24 at 12:54 p.m., revealed Resident #31 in the bed with the indwelling urinary catheter on the left side of the bed. CNA B was in Resident #31's room to provide catheter care but Resident #31 refused care. CNA B then stated, she would empty Resident #31's indwelling urinary catheter bag. CNA B washed her hands, put on a pair of gloves and emptied Resident #31's indwelling urinary catheter bag of urine and emptied the contents into the toilet. CNA B did not wear a gown per enhanced barrier precautions. During a follow-up interview on 5/2/24 at 1:09 p.m., CNA B revealed the believed enhanced barrier precautions applied to residents who received barrier cream. CNA B believed those residents identified on enhanced barrier precautions were identified on the POC (Point of Care) used by the CNA staff. CNA B stated, enhanced barrier precautions were to do with barrier cream and not anything to do with PPE (personal protective equipment). CNA B further revealed, whenever a resident had an open wound and also during wound care, then we would be wearing a gown and shield with the gloves. CNA B revealed for a resident on isolation due to an infection, there would be a yellow isolation sign on the resident's door with precautions and a cart set up with PPE on the outside of the room. f. Record review of Resident #34's face sheet, dated 4/30/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included neuromuscular dysfunction of bladder, and acute respiratory failure with hypoxia (develops when the lungs can't get enough oxygen into the blood). Record review of Resident #34's most recent quarterly MDS assessment, dated 4/20/24 revealed the resident was moderately cognitively impaired for daily decision-making skills, had an indwelling urinary catheter and had a feeding tube. Record review of Resident #34's order summary report, dated 4/30/24 revealed the following: - enteral feed order every shift check residual before medications and feedings; return contents after each check. Hold feeding if residual greater than 100 ml's, with order dated 9/8/22 and no end date. - enteral feed order every shift cleanse g-tube site and change dressing, with order date 11/24/23 and no end date. - Change foley (indwelling urinary catheter) as needed or for leakage, sediment, clogged with order date 4/30/24 and no end date. -Change foley catheter every month every night shift starting on the 10th and ending on the 10th every month for peri care with order date 3/1/23 and no end date. -Clean peg tube site with normal saline, pat dry, apply clean/dry split gauze every night shift with order date 11/24/23 and no end date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's comprehensive care plan, with revision date 2/5/24 revealed the resident had an indwelling urinary catheter with interventions to change the catheter as ordered, check tubing for kinds and maintain the drainage bag off the floor. Further review of Resident #34's comprehensive care plan revealed the resident required enteral feedings with interventions to check for tube placement and gastric contents/residual volume per facility protocol and the comprehensive care plan did not include interventions for enhanced barrier precautions. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #34 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 11:42 a.m. revealed Resident #34 in her bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/1/24 at 9:19 a.m. revealed Resident #34 in her bedroom and there were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. Observation on 5/2/24 at 8:39 a.m., LVN C washed her hands, then took a paper towel to dry her hands, and then used the same paper towel to turn off the water faucet. LVN C then provided medications to Resident #34 via a feeding tube but did not wear a gown per enhanced barrier precautions. During an interview on 5/2/24 at 8:55 a.m., LVN C stated, she should have grabbed another paper towel to turn off the faucet because it could be considered cross contamination. LVN C further stated, whatever residue was left on my hand from drying it could be on the faucet. g. Record review of Resident #35's most recent MDS assessment, dated 4/16/24 revealed a recent admitted [DATE], diagnoses of diabetes and asthma. The MDS revealed the resident's cognition was intact and he had an indwelling catheter. Record review of Resident #35's order summary report, dated 5/2/24 revealed the following: - Urinary Catheter 20F/30cc to gravity drainage every shift for Neurogenic bladder, with an order date of 9/22/23, and no end date. - provide catheter care every shift, with order date 9/23/23 and no end date. Record review of Resident #35's comprehensive care plan, with revision date 4/20/24 revealed the resident had obstructive uropathy (excess urine accumulation in kidney(s) that causes swelling of kidneys) Catheter:20F/30cc and with interventions that included to the resident has 20F/30cce. Position catheter bag and tubing below the level of the bladder and in a privacy bag, change catheter as ordered, check tubing for kinks and maintain the drainage bag off the floor. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #35 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/30/24 at 11:41 a.m. Resident #35 in the hallway outside his room while staff H cleaned his room. Resident #35 was sitting in his wheelchair and his catheter was hanging on the bottom of his chair touching the floor. The catheter bag was a solid color purple on one side and clear on the other side and urine was visible from that side. There were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions. RN F and CNA G assisted resident with his catheter that was touching the floor. The staff did not have on gowns. h. Record review of Resident #41's face sheet, dated 5/02/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included gastrostomy status (insertion is the placement of a feeding tube through the skin and the stomach wall). Record review of Resident #41's admission MDS assessment, dated 4/15/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had a feeding tube. Record review of Resident #41's MAR dated 5/2/24 revealed an order for enteral feed order every night shift cleanse g-tube site and was marked as completed last on 5/1/24. Record review of Resident #41's comprehensive care plan, with revision date 4/30/24 revealed the resident required tube feeding related to swallowing problems, with interventions clean insertion site daily as ordered, monitoring for s/s infection or breakdown. Record review of the facility document titled, Enhanced Barrier Precautions, undated, revealed Resident #41 had been identified requiring Enhanced Barrier Precautions related to having an indwelling catheter. Observation on 4/30/24 at 10:37 a.m. revealed Resident #41 was in his bedroom and a feeding tube syringe was on his bedside table. There were no enhanced barrier precaution signs or any indication the resident was on enhanced barrier precautions and no PPE gowns noted in the room or nearby. During an interview on 5/2/24 at 1:17 p.m. CNA G stated no residents were on enhanced precautions and were on standard precautions only. CNA G stated he only needed to wear gloves during care with all residents. CNA G stated he had recently started and was trained over contact precautions and droplet precautions but had never heard of enhanced barrier precautions and did not know what enhanced barrier precautions was. During an interview on 5/2/24 at 1:21 p.m. LVN A stated no residents (resident # 14, #21, #23, #35, and #41) under her care required staff to wear a gown for care. LVN A stated PPE gowns were available for use if needed on the other side of the building at a different nurse's station, but they did not need them. LVN A stated she started 2 weeks prior and did not know what enhanced barrier precautions were and had received not training on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 1:43 p.m., the DON revealed the facility had received a provider letter from corporate on enhanced barrier precautions, recently. The DON stated she and the ADON were responsible for in-service training, but the enhanced barrier precautions training was done by the facility computer training program. The DON stated she had a list of those residents who were supposed to be on enhanced barrier precautions and was in the process of implementing by adding signage and PPE supplies for each resident bedroom identified. The DON stated, I don't know why it wasn't done, I'm responsible, but we're working on it. The DON further revealed, residents were at risk for infection if staff were not following the enhanced barrier precautions. During an interview on 5/2/24 at 2:17 p.m., the ADON revealed enhanced barrier precautions training was provided to the staff on the facility computer training program. The ADON further revealed she was responsible for ensuring new staff were in-serviced for following enhanced barrier precautions. The ADON revealed the enhanced barrier precautions was in place for infection control purposes. 2. Record review of Resident #22's face sheet, dated 5/3/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), muscle wasting, lack of coordination and adult failure to thrive. Record review of Resident #22's most recent quarterly MDS assessment, dated 4/19/24 revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #22's Order Summary Report, dated 5/3/24 revealed the following: - Triamcinolone Acetonide External Ointment 0.1%, apply to left arm and left thigh topically two times a day for rash, with order date 3/12/24 and no end date - Voltaren External Gel 1%, apply to right knee topically two times a day for pain - May apply barrier cream as needed, with order date 10/28/21 and no end date Record review of Resident #22's comprehensive care plan revealed the resident had diabetes with interventions that included to monitor for signs and symptoms of infection to any open areas. Observation on 4/30/24 at 3:48 p.m., revealed Resident #22 on the bed and LVN A entered the room to obtain an accu check. LVN A put on a pair of gloves, did not utilize proper hand hygiene, and then obtained a sample of blood from Resident #22's finger without properly sanitizing the area. LVN A then removed her gloves, did not utilize proper hand hygiene and put on a pair of gloves and applied topical medication to resident #22's left forearm and thigh. LVN A then removed her gloves, did not utilize proper hand hygiene, put on a pair of gloves, and applied topical medication to Resident #22's back. During an interview on 4/30/24 at 3:48 p.m., Resident #22 stated, LVN A did not use an alcohol wipe to clean his finger before obtaining an accu check and further stated, most of the nurses used an alcohol wipe, but LVN A did not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/24 at 4:05 p.m., LVN A stated she had not used an alcohol wipe to sanitize Resident #22's finger before obtaining the accu check and further stated, I was afraid you were going to catch that. LVN A revealed, the area used for the accu check needed to be sanitized prior to prevent infection. LVN A confirmed she had not washed or sanitized her hands before and after glove changes and had read somewhere that it was not necessary, only to change gloves because I am going to different parts of the body. LVN A revealed she was not sure what the facility policy was on hand hygiene between glove changes. During an interview on 5/2/24 at 5:42 p.m., the DON revealed it was her expectation, when obtaining an accu check from the resident, staff must sanitize the area first with an alcohol wipe before the area is punctured with a needle. The DON stated, if the area was not cleaned before punctured with a needle the area could become infected. The DON further revealed, hand hygiene should be utilized before and after glove changes to prevent cross contamination and was considered an infection control issue resulting in the resident getting an infection. 3. Record review of Resident #34's face sheet, dated 4/30/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included neuromuscular dysfunction of bladder, and acute respiratory failure with hypoxia (develops when the lungs can't get enough oxygen into the blood). Record review of Resident #34's most recent quarterly MDS assessment, dated 4/20/24 revealed the resident was moderately cognitively impaired for daily decision-making skills, had an indwelling urinary catheter and had a feeding tube. Record review of Resident #34's order summary report, dated 4/30/24 revealed the following: - enteral feed order every shift check residual before medications and feedings; return contents after each check. Hold feeding if residual greater than 100 ml's, with order dated 9/8/22 and no end date. - enteral feed order every shift cleanse g-tube site and change dressing, with order date 11/24/23 and no end date. -Clean peg tube site with normal saline, pat dry, apply clean/dry split gauze every night shift with order date 11/24/23 and no end date. Record review of Resident #34's comprehensive care plan, with revision date 2/5/24 revealed the resident required enteral feedings with interventions to check for tube placement and gastric contents/residual volume per facility protocol. Observation on 5/2/24 at 8:39 a.m., during the medication pass revealed LVN C washed her hands, then took a paper towel to dry her hands, and then used the same paper towel to turn off the water faucet. LVN C then provided medications to Resident #34 via a feeding tube. During an interview on 5/2/24 at 8:55 a.m., LVN C stated, she should have grabbed another paper towel to turn off the faucet because it could be considered cross contamination. LVN C further stated, whatever residue was left on my hand from drying it could be on the faucet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #18's face sheet, dated 5/3/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), personal history of infectious and parasitic diseases and morbid obesity. Record review of Resident #18's most recent quarterly MDS assessment, dated 4/10/24 revealed the resident was cognitively intact for daily decision-making skills. Observation on 5/2/24 at 7:23 a.m., during the medication pass revealed Med Aide D washed her hands, then took a paper towel to dry her hands, and then used the same paper towel to turn off the water faucet. Med Aide D then provided medications to Resident #18. During an interview on 5/2/24 at 7:50 a.m., Med Aide D revealed she had used a paper towel to dry her hands and then used the same paper towel to turn off the water faucet. Med Aide D revealed, using the same paper towel to dry her hands and to turn off the water faucet was considered cross contamination and could result in spreading germs. Med Aide D then stated, we were taught that when we finished drying our hands with the towel, I could use the same towel to turn off the faucet. During an interview on 5/2/24 at 5:42 p.m., the DON revealed it was her expectation for staff to toss out the paper towel after drying their hands and get a new towel to turn off the faucet because it was considered going from a clean area to a dirty area. The DON stated, there's always a potential for something, like cross contamination or infection. Record review of the facility training document titled Enhanced Barrier Precaution, dated 3/27/24 revealed in part, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing .A single set of PPE cannot be used for more than 1 patient . EBP are indicated for residents with any of the following Wounds and/or indwelling medical devices even if the resident is not known to be infected .Wounds generally include chronic wounds .pressure ulcers . Indwelling medical device examples include central lines, urinary catheters, feeding tubes .The facility will ensure PPE and alcohol-based hand rub are readily accessible to staff prior to entry to their room .Donning PPE for residents on EBP based on activity provided/Assistance while in resident room .perform wound care; any skin opening requiring a dressing .device care or use: central line, urinary catheter, feeding tube .The facility will utilize postings outside the room .and to communicate to staff if a resident requires EBP . Record review of the facility policy and procedure titled, Hand Hygiene, undated, revealed in part, .You may use alcohol-based hand cleaner or soap/water for the following .before and after performing any invasive procedure (e.g. fingerstick blood sampling) .after removing gloves . 45857

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 45857 Based on observation, interview, and record review the facility failed to ensure that 46 of 49 multiple occupancy Resident rooms provided a minimum of 80 square feet per resident room. This deficient practice could affect all residents in need of at least 80 square feet of living space and could pose problems in the Residents' activities of daily living. The findings were: During an interview with the Administrator on 4/30/24 at the Administrator revealed he wanted to continue with the room waiver on all resident rooms, which did not meet the required square footage. Information provided revealed the following measurements for resident rooms: Rooms: #2 (146) 73 square feet with 2 beds in the room #3 (147) 73.5 square feet with 2 beds in the room #4 (147.6) 73.8 square feet with 2 beds in the room #5 (147.1)73.5 square feet with 2 beds in the room #7 (147) 73.5 square feet with 2 beds in the room #9 (146.3) 73.1 square feet with 2 beds in the room #10 (146.3) 73.15 square feet with 2 beds in the room #11 (147.1) 73.5 square feet with 2 beds in the room #12 (147.1) 73.5 square feet with 2 beds in the room #13 (146.9) 73.4 square feet with 2 beds in the room #14 (146) 73 square feet with 2 beds in the room #15 (145.77) 72.82 square feet with 2 beds in the room #16 (145.77) 72.82 square feet with 2 beds in the room #17 (146.27) 73 square feet with 2 beds in the room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	#18 (145.23) 72.62 square feet with 2 beds in the room #19 (145.23) 72.62 square feet with 2 beds in the room #20 (145.23) 72.62 square feet with 2 beds in the room #21 (145.53) 72.76 square feet with 2 beds in the room #22 (148.403) 74.20 square feet with 2 beds in the room #23 (147.811) 73.91 square feet with 2 beds in the room #24 (148.282) 74.14 square feet with 2 beds in the room #25 (147.465) 73.73 square feet with 2 beds in the room #26 (148.664) 74.33 square feet with 1 bed in the room #27 (147.919) 73.96 square feet with 2 beds in the room #28 (146.937) 73.47 square feet with 2 beds in the room #29 (147.571) 73.79 square feet with 2 beds in the room #30 (152.176) 76.09 square feet with 2 beds in the room #32 (158.190) 79.10 square feet with 2 beds in the room #34 (149.669) 74.83 square feet with 2 beds in the room #35 (162.480) 81.24 square feet with 2 beds in the room #36 (148.516) 74.26 square feet with 2 beds in the room #37 (155.894) 77.95 square feet with 2 beds in the room #38 (140.45) 70.23 square feet with 2 beds in the room #39 (147.921) 73.96 square feet with 2 beds in the room #40 (147.244) 73.62 square feet with 2 beds in the room #41 (149.234) 74.62 square feet with 2 beds in the room #42 (157.707) 78.85 square feet with 2 beds in the room #43 (160.834) 80.42 square feet with 2 beds in the room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	#44 (157.169) 78.58 square feet with 2 beds in the room #45 (157.169) 78.58 square feet with 2 beds in the room #46 (155.038) 77.52 square feet with 2 beds in the room #47 (153.302) 76.65 square feet with 2 beds in the room #48 (153.728) 76.86 square feet with 2 beds in the room #49 (149.055) 74.53 square feet with 2 beds in the room #50 (148.311) 74.311 square feet with 2 beds in the room #51 (159.466) 79.73 square feet with 2 beds in the room Information provided by the facility on 04/30/24 revealed a census of 42 Residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 45857 Based on interview and record review, the facility failed to provide mandatory effective behavioral health training for 1 of 14 employees (DON) reviewed for training, in that: The facility failed to ensure effective behavioral health training was provided to the DON. This failure could place residents at risk of not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. The findings included: Review of the DON's personnel record had a hire date of 10/19/23 revealed no evidence of behavioral health training. During a record review and interview on 5/3/24 at 10:25 a.m. the BOM/HR Personnel revealed the DON did not have the required behavioral health training. During an interview on 5/3/24 at 4:36 p.m. the DON stated she completed training that was assigned to her. The DON stated she was unsure why she had not done the training but had received it at other places she had worked at and was also unsure how it could affect the residents. A policy for training was requested and not provided.